PRINTED: 01/15/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345404	B. WING _			C 11/16/2018	
	ROVIDER OR SUPPLIER VERS HEALTH AND REF	-IAB		STREET ADDRESS, CITY, STATE, ZIP COI 1403 CONNER DRIVE WINDSOR, NC 27983	DE	11/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 0	00			
F 500	complaint investigation					40/44/40	
F 580 SS=D	CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) -)(i)-(iv)(15)	F 5	80		12/14/18	
	consult with the resid consistent with his or representative(s) who (A) An accident involves results in injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter the a need to discontinue treatment due to advect commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informati is available and proviphysician. (iii) The facility must a resident and the resid when there is-(A) A change in room as specified in §483.	rediately inform the resident; ent's physician; and notify, her authority, the resident en there isving the resident which as the potential for requiring n; ge in the resident's physical, sial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, a n existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the dent representative, if any, or roommate assignment					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 12/10/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345404	B. WING		C 11/16/2018	
	ROVIDER OR SUPPLIER VERS HEALTH AND RE		STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 580	(e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a compthat is a composite of §483.5) must disclosits physical configural locations that compripart, and must specif room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revinterviews the facility and responsible partices pressure ulcer for 1 copressure ulcer care. Findings included: Resident #304 was a 1/19/18. Her active diartery disease, heart insufficiency, Alzhein a history of colon care.	ons as specified in paragraph in. record and periodically mailing and email) and resident resi	F 58	F580 The statements made on this plan of correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all feet and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of corrections that all alleged deficiencies cited have been or will corrected by the dates indicated. 1. Plan for correcting specific deficiencies deficiencies defici	end do e deral s taken nis ection f be ency.	
	revealed she was as cognitively impaired. assessed to require a personal hygiene and	-		The process that led to deficiency of the facility failed to notify the physicand responsible party of a newly idepressure ulcer for 1 of 2 residents reviewed for pressure ulcer care.	cian	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345404	B. WING _			11/	16/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
TUDEE DI	VERS HEALTH AND REH	JAD		14	103 CONNER DRIVE			
ITKEE KI	VERS HEALTH AND KER	IAD		W	/INDSOR, NC 27983			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 580	Continued From page	e 2	F 5	80				
	the assessment.				(Resident#304)			
	1/23/18 revealed she risk for pressure ulcer bowel and bladder indability to assist with re				On 12/10/18, an LPN Support Nurse completed a 100% review on all reside 57 current residents audited of which 8 have pressure ulcers. All RP's and Physicians were notified.			
		I to observe Resident #304's ben areas and inform the re noted.			2. The procedure for implementing the acceptable plan of correction- for the			
	Nurse #1 performed a noted an old ulcer to	ote dated 4/18/18 revealed a skin assessment and the sacrum had reopened			specific deficiency cited: - On 12-10-17, The Administrator and Director of Nursing began in servicing a	all		
	or odors were noted. placed over the area	er in diameter. No drainage A hydrocolloid dressing was per standing orders and was no documentation of			FT, PT, and PRN RN's and LPN's, Admissions and Social Services Assist on the following procedures:	ant		
	the RP or physician b	eing notified.			 Notification of Changes- A facility must immediately inform the resident; 			
	Nurse #1 stated she r	n 11/14/18 at 11:54 PM MDS received report from the ge II pressure ulcer had			consult with the resident's physician; a notify, consistent with his or her author the resident representative(s) when the	ity		
	initiated according to She further stated she	ressing changes had been physician standing orders. e assumed the physician			is (A) and accident involving the reside which results in injury and has the potential for requiring physician			
	not contact the physic				intervention; (B) a significant change in the resident's physical, mental, or psychosocial status (that is a deterioral	tion		
	#1 stated she was the	n 11/14/18 at 3:27 PM Nurse e nurse who discovered n old, healed wound open to			in health, mental, or psychosocial statu either life-threatening conditions or clin complications); (C) A need to alter			
	be about 0.5 centimes sacrum. She further s	ters with no drainage to her tated there were standing tho developed a stage I or II			treatment significantly that is, a need to discontinue an existing form of treatme due to adverse consequences, or to			
	and placed a hydrocoresident. Nurse #1 sta	ne followed those orders illoid dressing on the ated when old wounds is followed the standing			commence a new form of treatment); o (D) a decision to transfer or discharge resident from the facility as specified in 483.15 (c)(1)(ii). The facility must also	the		

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345404		B. WING		С		
NAME OF PROV	(IDED OD OLIDDI IED	343404	B. WING_	OTE	OFFI ADDRESS SITV STATE 7/D SODE	11/	16/2018	
NAME OF PROV	IDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
THREE RIVE	RS HEALTH AND REI	НАВ			3 CONNER DRIVE			
				WI	NDSOR, NC 27983			
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or www.documents.com. www.documents.com. com. documents.com. com. com. com. com. com. com. com.	ounds themselves. rote a nurse's note a commenting how Reseatment, and that wurse #1 further state bened wound to the uring change of shift was. The nurse state ound care nurse, are opened wound, it due physician or RP. uring an interview of irector of Nursing state Nurse #1 notify the physician about the saure of the new are terdisciplinary team 304. The Director of hid physician were more sure ulcer on 4/2 uring an interview of hysician #1 stated it of tified by staff if a reseasure ulcer reoper	s took care of reopened She further stated she then about the dressing sident #304 tolerated the as all she needed to do. ed she then reported the oncoming day shift nurse t but did not remember who ted the facility did not have a o she did not report it to any nd because it was a id not need to be reported to an 11/14/18 at 4:07 PM the cated it was her expectation the Director of Nursing, RP, the development of new further stated she was not a until 4/24/18 during an a meeting regarding Resident f Nursing concluded the RP made aware of the new 4/18 as well. an 11/15/18 at 8:28 AM at was his expectation to be esident 's old, healed med. He concluded Nurse #1 his office after the pressure	F	580	promptly notify the resident and the resident representative, if any, when the is a (A) A change in room or roommate assignment as specified in 483.10(e)(6 or (B) A change in resident rights unde Federal or State law or regulations as specified in paragraph (e) (10) of this section. The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Any in-house staff member who did not receive in-service training by 12-14-20 will not be allowed to work until training has been completed. This information heen integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements: The Administrator, Director of Nursing MDS Coordinator will conduct audits to ensure the Resident, Physician, and the Resident Representative were notified Resident's with newly identified pressuratives. These audits will be conducted weekly for two weeks and monthly for a months. This monitoring will continue unresolved by QOL/QA committee. Report	t 18 has tt at		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345404	B. WING _			11/	16/2018
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F 580		overage/Liability Notice		580	committee by the Administrator or DON ensure corrective action initiated as appropriate. Compliance will be monito and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the Administrate DON, MDS Coordinator, Therapy, HIM and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	red d at A or,	12/14/18
SS=B	writing, at the time of facility and when the Medicaid of- (A) The items and ser nursing facility services for which the resident (B) Those other items facility offers and for charged, and the amoservices; and (ii) Inform each Medic changes are made to specified in §483.10(g) section. §483.10(g)(18) The faresident before, or at periodically during the available in the facility	acility must aid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and					

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F 582	facility's per diem rat (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes a items and services th facility must inform th 60 days prior to impl (iii) If a resident dies transferred and does facility must refund to representative, or es deposit or charges a per diem rate, for the resided or reserved of facility, regardless of discharge notice req (iv) The facility must resident representati the resident within 30 date of discharge fro (v) The terms of an a behalf of an individua facility must not conf these regulations.	care/ Medicaid or by the e. coverage are made to items d by Medicare and/or by the the facility must provide f the change as soon as is are made to charges for other that the facility offers, the the resident in writing at least the mentation of the change. The or is hospitalized or is the not return to the facility, the to the resident, resident tate, as applicable, any the days the resident actually the facility or retained a bed in the the any minimum stay or the days from the resident or the ve any and all refunds due of days from the resident's the facility. The difference of	F5	· · · · · · · · · · · · · · · · · · ·		
	by: Based on record rev facility failed to provi and Medicaid Servic Facility Advanced Be discharge from Medi for 2 of 3 residents re	T is not met as evidenced view and staff interviews, the de a Centers for Medicare es (CMS) Skilled Nursing eneficiary Notice prior to care Part A skilled services eviewed for beneficiary in review (Residents #13 and		F582 The statements made on this plat correction are not an admission to not constitute an agreement with alleged deficiencies. To remain in compliance with all fand state regulations the facility hor will take the actions set forth in plan of correction. The plan of co	o and do the federal nas taken n this	

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NAME OF PR	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CO	•	1710/2010	
				1403 CONNER DRIVE			
THREE RI	VERS HEALTH AND RI	EHAB		WINDSOR, NC 27983			
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F 582	Continued From page	ge 6	F 5	82			
	The findings included 1. Resident #13 was 5/31/18 with diagnotobstructive pulmonal disease, and spinal readmitted to Medica 8/24/18. Resident #13's Medical ended on 9/6/18. Second review revenot given the CMS-Non-Coverage lette	ed: as admitted to the facility on ses including chronic ary disease, diabetes, heart		constitutes the facility's allege compliance such that all alled deficiencies cited have been corrected by the dates indicated. 1. Plan for correcting specification and the process that led to defice the process that led to defice the process that led to provide the Medicare and Medicaid Services and Skilled Nursing Facility Advarsation and the protection specification and the protection notification review #13 and #30).	ged or will be ated. c deficiency. ciency cited. a Centers for vices (CMS) anced ischarge from ices for 2 of 3 ficiary		
	During an interview 11/14/18 at 4:50 PM hired as the Busines her responsibility to resident represental skilled services were remaining at least the of services. The Bladditional responsibility or resident represer should Part A skilled stated she utilizes the CMS-10555 SNF-A notification. The Blads was not responsible to Resident #13. During an interview 11/14/18 at 4:59 PM expectation the facinguidelines and proving the responsibility of the services of t	with the Business Officer on I, she stated she was recently as Officer. She reported it is inform the resident or the tive that Medicare Part A is ending with benefit days aree days prior to termination usiness Officer reported an oblity is to advise the resident attaive of the cost of services as services continue. She in e CMS-10123 NOMNC and BN to give this written usiness Officer indicated she is for giving these notifications with the Administrator on I, she stated it is her lity follows the CMS Federal ide the CMS-10123 NOMNC is SNF-ABN to the resident or		The procedure for implement acceptable plan of correction specific deficiency cited: - The Regional Business Officin-serviced the Admissions/Social Vocations of Social Worker Assistant on the procedures: • The facility must inform Medicaid eligible resident in time of admission to the nurse and when the resident become for Medicaid and the facility each resident before, or at the admission, and periodically resident's stay, of services a facility and of charges for the including any charges for secovered under Medicare/Medic	each writing, at sing facility mes eligible must inform he time of during the available in the ose services, rvices not		

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345404	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	3-3-0-		STREET ADDRESS, CITY, STATE, ZIP CODE	•	1/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	1		
THREE RI	VERS HEALTH AND REI	IAB		1403 CONNER DRIVE			
				WINDSOR, NC 27983			
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F 582	Continued From page	e 7	F 58	32			
	resident representativ	ve when required.		the facility's per diem rate, Wh	ere		
	Toolaon Toprocontain	wien required.		changes in coverage are made			
	2 Resident #30 was	admitted to the facility on		and services covered by Medi			
	3/16/18 with diagnose			by the Medicaid State plan, the			
	diabetes mellitus, and	•		must provide notice to Resider	•		
		re Part A skilled services on		change as soon as is reasona			
	5/3/18.	TO T UTC / CIKINGU GOT VIGGO GIT		onange as soon as is reasona	ory possible.		
	0.0.10.			F582 in its entirety			
	Resident #30's Medic	care Part A skilled services		CMS-10123 Notice of Meaning Company	dicare		
		he remained in the facility.		Non-Coverage Letter (NOMN			
		ed that Resident #30 was		CMS-10555 Skilled Nursii			
		0123 Notice of Medicare		Advanced Beneficiary Notice (
		(NOMNC)or the CMS-10555			,		
		ty Advanced Beneficiary		Any in-house staff member wh	o did not		
	Notice (SNF-ABN).	,		receive in-service training by 1			
	,			will not be allowed to work unt			
	During an interview w	rith the Business Officer on		has been completed. This info	rmation has		
	11/14/18 at 4:50 PM,	she stated she was recently		been integrated into the stand	ard		
	hired as the Business	Officer. She reported it is		orientation training and in the	required		
	her responsibility to in	nform the resident or the		in-service refresher courses for	r all		
	resident representativ	e that Medicare Part A		employees and will be reviewe	d by the		
	skilled services were	ending with benefit days		Quality Assurance process to	verify that		
		ee days prior to termination		the change has been sustaine	d.		
		siness Officer reported an					
		ity is to advise the resident		The monitoring procedure to e			
		ative of the cost of services		the plan of correction is effecti			
		services continue. She		specific deficiency cited remain			
		e CMS-10123 NOMNC and		and/or in compliance with the	regulatory		
	CMS-10555 SNF-AB			requirements:			
		iness Officer indicated she					
		or giving these notifications		The Administrator will conduct			
	to Resident #30.			ensure the facility has provide			
	Demine and the t	ittle the e. A charitain to t		CMS-10123 Notice of Medicar			
	_	vith the Administrator on		Non-Coverage letter (NOMNC	•		
	11/14/18 at 4:59 PM,			CMS 10555 Skilled Nursing Fa	-		
		y follows the CMS Federal		Advanced Beneficiary Notice (
		e the CMS-10123 NOMNC		These audits will be conducted			
		SNF-ABN to the resident or		two weeks and monthly for 3 n			
	resident representative	ve wnen required.		monitoring will continue until re	esoived by		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 623 SS=B	CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility trans- resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a co- representative of the Long-Term Care Omb (ii) Record the reason discharge in the residence accordance with para and (iii) Include in the noti paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified	Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or lent's medical record in legraph (c)(2) of this section; ce the items described in is section.		QOL/QA committee. Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropri Compliance will be monitored and ongoing auditing program reviewed a weekly QA Meeting. The weekly QA Meeting is attended by the Administra DON, MDS Coordinator, Therapy, HI and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	ate. t the ator, M,	

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F 623	made by the facility a resident is transferred (ii) Notice must be more before transfer or dis (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's heallow a more immediated under paragraph (c)((D) An immediate transferred by the residual under paragraph (c)((E) A resident has not days. §483.15(c)(5) Conternotice specified in paramust include the follod (i) The reason for tradici) The effective date (iii) The location to with transferred or dischalation (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omitice (iii) Terminate (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Care Omitice (iii) The name, address telephone number of Long-Term Car	ander this section must be at least 30 days before the dor discharged. ade as soon as practicable charge when-viduals in the facility would a paragraph (c)(1)(i)(C) of viduals in the facility would be paragraph (c)(1)(i)(D) of viduals in the facility would be paragraph (c)(1)(i)(D) of viduals in the facility would be paragraph (c)(1)(i)(D) of viduals in the facility would be paragraph (c)(1)(i)(D) of viduals in the facility to ate transfer or discharge, 1)(i)(B) of this section; ansfer or discharge is bent's urgent medical needs, 1)(i)(A) of this section; or of the interest of the facility for 30 on the soft the notice. The written tragraph (c)(3) of this section owing: ansfer or discharge; the of transfer or discharge; thich the resident is a freed; the resident is a facility which start in the office of the State of the Sta	F 623			

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	ROVIDER OR SUPPLIER VERS HEALTH AND RE	нав	STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983				
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F 623	telephone number of the protection and addevelopmental disable. C of the Developmer and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related diemail address and the agency responsible fadvocacy of individual established under the for Mentally III Individual established under the formation in the effecting the transfer must update the reci as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification proto the State Survey A State Long-Term Call the facility, and the rewell as the plan for the relocation of the residual establishment	disabilities or related and and email address and if the agency responsible for dvocacy of individuals with dilities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and the ty residents with a mental sabilities, the mailing and delephone number of the for the protection and als with a mental disorder delephone number of the for the protection and Advocacy duals Act. The set to the notice of discharge, the facility prients of the notice as soon the updated information In advance of facility closure closure, the individual who is the facility must provide for to the impending closure agency, the Office of the re Ombudsman, residents of desident representatives, as the transfer and adequate dents, as required at § This not met as evidenced the written notice of discharge eviewed for hospitalization	F 62	F623 The statements made on this progrection are not an admission of constitute an agreement with the statement with the statement with the statement of the statement with the statemen	n to and do		

NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH AND REHAB (X4 ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 11 The findings included: 1. Resident #15 was admitted to the facility on 7/31/18. His diagnoses included: congestive heart failure, chronic kidney disease and atrial fibrillation. Review of a nurse's note dated 10/18/18 revealed Resident # 15 was sent to the hospital for evaluation for major renal failure. A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 10/18/18. No written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She continued she STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983 PREFIX (EACH DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. The facility failed to provide written notice of discharge for 2 of 2 re	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983	3) DATE SURVEY COMPLETED
THREE RIVERS HEALTH AND REHAB SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 11 The findings included: 1. Resident #15 was admitted to the facility on 7/31/18. His diagnoses included: congestive heart failure, chronic kidney disease and atrial fibrillation. Review of a nurse's note dated 10/18/18 revealed Resident # 15 was sent to the hospital for evaluation for major renal failure. A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 10/18/18. No written notice was forwarded to the ombudsman. During an interview with the Admissions Coordinator on 11/15/18 at 12:31 PM, she stated that she was unaware that written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She continued she	С
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 11 The findings included: 1. Resident #15 was admitted to the facility on 7/31/18. His diagnoses included: congestive heart failure, chronic kidney disease and atrial fibrillation. Review of a nurse's note dated 10/18/18 revealed Resident # 15 was sent to the hospital for evaluation for major renal failure. A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 10/18/18. No written notice was forwarded to the ombudsman. During an interview with the Admissions Coordinator on 11/15/18 at 12:31 PM, she stated that she was unaware that written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She continued she	
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would ensure written notice of discharge is sent to the resident or resident's representative with a copy to the ombudsman for future hospital transfers. An interview was conducted with the Administrator on 11/15/18 at 2:11PM, who indicated it was her expectation written notice of discharge would be sent to the resident or resident's representative with a copy forwarded to acceptable plan of correction- for the specific deficiency cited: - The Administrator, Director of Nursing, began in servicing all FT, PT, and PRN RN's, LPN's, Admissions and Social Worker Assistant on the following procedures:	
the ombudsman as required by regulations for emergent hospital transfers by the Admission Coordinator. Coordinator. 2. Resident #14 was admitted to the facility on 11/17/17. His active diagnoses included dementia, chronic kidney disease, osteoarthritis, and hyperlipidemia. Review of Resident #14's nurses notes revealed on 8/1/18 he was order to be transferred to the • Notice before Transfer, before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative (s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman. • F623 in its entirety	е

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 623	hospital following the Review of Resident # written notice of dischresident or resident ' notice of discharge w ombudsman. During an interview of Admissions Coordinate aware of the regulation transfer being sent to resident or family regulations. During an interview of Administrator stated in notification of discharcesident, resident rep	report of an abnormal lab. 214's chart revealed no harge was provided to the serpresentative. No written has forwarded to the serpresentative as forwarded to the serpresentative. The serpresentative as forwarded to the serpresentative at 1:38 PM the storestated she was not concerning the notice of the ombudsman and serpresentative at 2:11 PM the serpresentative, and forwarded serpresentative, and forwarded serpresentative, and forwarded serpresentative at 1:45 per service at 1:45	F 623	Any in-house staff member who did not receive in-service training by 12-14-20 will not be allowed to work until trainin has been completed. This information been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify the change has been sustained. The monitoring procedure to ensure the plan of correction is effective and a specific deficiency cited remains correction in compliance with the regulator requirements: The Administrator or Director of Nursin will conduct audits to ensure the facility has provided Notice before Transfer, Before a facility transfers or discharge resident, the facility must notify the resident and the resident's representation (s) of the transfer or discharge and the reasons for the move in writing and in language and manner they understan. The facility must send a copy of the note a representative of the Office of the State Long Term Care Ombudsman. These audits will be conducted weekly two weeks and monthly for 3 months. monitoring will continue until resolved QOL/QA committee. Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropriate Compliance will be monitored and	has has has e at hat chat cated nry ng y s a tive e a d. otice / for This by e by	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
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F 623	Continued From page	÷ 13	F6	ongoing auditing program reviewed at t weekly QA Meeting. The weekly QA Meeting is attended by the Administrate DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	or,	
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)(F6			12/14/18
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac the resident and the r An explanation must i medical record if the r and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by th (iii)Reviewed and revi	orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resentative is determined e development of the e staff or professionals in ined by the resident's needs				

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F 657	Continued From page	e 14	F 6	557			
		uarterly review is not met as evidenced					
	by:	iew, staff, resident, and			F657		
		e interviews the facility			The statements made on this plan of		
		arterly interdisciplinary care			correction are not an admission to and	do	
		1 residents reviewed for			not constitute an agreement with the		
	care plans. (Resident	: #13)			alleged deficiencies.		
					To remain in compliance with all federa		
	Findings included:				and state regulations the facility has tal	ken	
					or will take the actions set forth in this		
		mitted to the facility on			plan of correction. The plan of correction	n n	
		agnose included chronic y disease, diabetes, heart			constitutes the facility's allegation of compliance such that all alleged		
	disease, and spinal s				deficiencies cited have been or will be		
	alocase, and opinal o	10110010.			corrected by the dates indicated.		
	Review of Resident #	13's most recent minimum			,		
	data set assessment	dated 8/31/18 revealed she			1. Plan for correcting specific deficience	y.	
	was assessed as cog	initively intact.			The process that led to deficiency cited The facility failed to perform a quarterly		
		31's records revealed there			interdisciplinary care plan meeting for 1	l of	
		disciplinary care plan			1 residents reviewed for care plans.		
	meeting held for Resi				For resident #13, a corrective action wa	as	
		B. During an interview on			obtained on 11/16/18.		
		Resident #13 stated she			A care plan meeting for resident #13 w		
	her admission on 5/3	to a care plan meeting since			conducted on 11/16/18. This meeting v	was	
	ner admission on 5/3	1/10.			attended by resident, resident's representative/husband, as well as faci	ility	
	During an interview o	n 11/15/18 at 9:33 AM			Interdisciplinary Team.	iity	
	_	onsible Party stated he had			On 11/15/18 and 12-10-2018, the MDS	,	
		a care plan meeting since			Coordinator and the Social Worker		
		en admitted on 5/31/18.			assistant conducted a 100% audit on a	.II	
					current residents to determine whether		
	During an interview o	n 11/15/18 at 1:41 PM			not they and/or their representative have		
		ator stated Resident #13 had			received invitations to their care planning	_	
	·	linary care plan meeting			conference during the past 90 days. The		
		on 5/31/18. She further			audit was completed by interviewing all		
	stated she did not kno	ow how or why she had not			alert and oriented residents to determin	ne	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 657	since her admission soon as possible. During an interview of Administrator stated interdisciplinary care to the care plan be d	meeting invitation or notice and would schedule one as on 11/15/18 at 2:10 PM it was her expectation plan meetings and updates one upon admission and not done for Resident #13.	F6		whether they have received an invitation to their care planning conference during the past 90 days or not. Validation of whether or not resident representatives had received invitations to care plannin conference during the past 90 days wa done by either interviewing the representative or by locating a copy of mailed invitation (including date mailed The results of this audit were: 12 residents did recall receiving invitation care planning conference during the past 90 days. 5 residents did not recall having received invitation to care planning conference during the past 90 days. 25 resident representatives had received invitation to care planning conference during past 90 days. 24 resident representatives had not received invitation to care planning conference during past 90 days. Based on the above audit, an invitation schedule and participate in a care planning conference was extended to a residents and/or representatives who have not been invited to participate in his/her care planning conference within the past 90 days. 2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - On 12/10/2018, the Minimum Data Set	g s s ng ns l). on ed ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 657	Continued From page	e 16	F 657	Nurse Consultant in-serviced the facili Minimum Data Set Nurse and Social Services Director on the importance a well as requirement to invite and involversidents and their representatives in planning conferences. Each resident should have an initial care planning conference during the first 72 hours of admission and on a quarterly basis. Tacility interdisciplinary team should be included in these care planning meeting. The facility should extend invitations to both the resident and their representational and encourage their involvement, as the are the best resources for coordinating individualized care plan. Upon admiss a 72 hour care plan conference should scheduled. Thereafter, either a verbal written invitation should be extended the resident on a quarterly basis. In addition, an invitation should be mailed the resident representative on a quarter basis. There are times when it is necessary to conduct the care planning meeting either at resident's bedside on telephone conference call in order to accommodate the resident and/or representative's needs. This information has been integrated in the standard orientation training for new Minimum Data Set Coordinators and Social Services Directors. The Director of Nursing or Minimum Data Set Nurse or designee will review 5 current residents to ensure that the resident as well as their representative.	s ve care care the engs. tive, hey gran sion, drape or condition or co	

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F 657	must have a discharg but is not limited to, th (i) A recapitulation of includes, but is not lin of illness/treatment or radiology, and consul (ii) A final summary or include items in parage the time of the dischar	i)-(iv) rge Summary sipates discharge, a resident e summary that includes, ne following: the resident's stay that nited to, diagnoses, course therapy, and pertinent lab,	Fé	haa paa coo wii "C Too for Re Qu Dii acc inii Qu the Se Nu Ma Acc Th im coo Acc Da	ave been invited to attend and articipate in their care planning inference during the past quarter. The street of the weekly been as the past of the weekly been as the past of the weekly been as the ports will be done on a weekly been as the presented to the weekly allity Assurance committee by the rector of Nursing to ensure corrective attention for trends or ongoing concerns it tiated as appropriate. The weekly allity Assurance Meeting is attended as a price of Nursing, Minimum Data at Coordinator, Unit Manager, Suppourse, Therapy, Health Information anager, Dietary Manager and the diministrator. The plementing the acceptable plan of the person responsible for plementing the acceptable plan of the person and for Director of Nursing attended to Compliance: 12/14/18	led asis y e s by	12/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 661	medications (both prover-the-counter). (iv) A post-discharge developed with the pand, with the residen representative(s), whadjust to his or her nepost-discharge plan of the individual plans to that have been made care and any post-disnon-medical services. This REQUIREMENT by: Based on record revisacility failed to compfor 1 of 1 residents redischarge from the fact (Resident # 52). The findings included Resident #52 was ad 7/27/18 with diagnosheart failure, atrial fib. Resident #52's admisdated 8/3/18 coded herequiring limited assistative and having discharged to the correct revision of Review of Resident # 52 here.	all pre-discharge resident's post-discharge escribed and plan of care that is articipation of the resident t's consent, the resident tich will assist the resident to ew living environment. The of care must indicate where or reside, any arrangements e for the resident's follow up scharge medical and office is not met as evidenced riew and staff interviews, the elete a recapitulation of stay eviewed for a planned acility to the community d: Imitted to the facility on es that included congestive orillation and hyperlipidemia. Sesion Minimum Data Set him cognitively intact, stance for most activities of g the expectation to be	F 66	The statements made on the correction are not an admiss not constitute an agreement alleged deficiencies. To remain in compliance with and state regulations the factor will take the actions set for plan of correction. The plan constitutes the facility's allege compliance such that all alled deficiencies cited have been corrected by the dates indicated: The plan of correcting the system of the plan of the plan of correcting the system of the plan	sion to and do with the h all federal cility has taken orth in this of correction gation of eged n or will be ated. pecific address the eficiency		

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failed to complete a re #52's stay in the facili The Director of Nursir interview on 11/15/18 discharging a residen completing the discharge the discharge recapitulati Resident #52's discharge retailed the nurse w #52 is no longer emplo DON stated it is her ecomplete the discharge resident's discharge. An interview was com Administrator on 11/1 stated it is her expect	ecapitulation of Resident ty. Ing (DON) stated during an at 12:38 PM, the nurse t is responsible for arge recapitulation section of arg. She stated the on was not completed on arge summary. She who discharged Resident loyed with the facility. The expectation all departments ge summary prior to a appleted with the 5/18 at 2:14 PM. She ation all sections of the	F 6	interviews, the factor recapitulation of stor a planned discommunity (Resident #formunity). Resident #52 was on 7/27/2018 with included congesting fibrillation and hypomorphisms and set dated 8/3/201 intact, requiring limost activities of the expectation to community. Review of Resider revealed he was community. Review of Resider revealed he was complete a recapitation and hypomorphisms and hypomorphisms and hypomorphisms are sident discharged gold and hypomorphisms. An audit was concurrented.	tay 1 of 1 resident revelor tharge from facility to the facility and the facility and the facility to the facility to the facility the facility that the facility facility facility for the facility failed to the	iew the ty ta ely d
	Continued From page failed to complete a resident with discharge recapitulating Resident #52's discharge recapitulating Resident #52's no longer emploon stated it is her ecomplete the discharge. An interview was completed it is her expect was continued to the complete of the discharge recapitulating Resident #52's discharge resident was completed the discharge resident it is her expect was completed in the respect was compl	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 failed to complete a recapitulation of Resident #52's stay in the facility. The Director of Nursing (DON) stated during an interview on 11/15/18 at 12:38 PM, the nurse discharging a resident is responsible for completing the discharge recapitulation section of the discharge summary. She stated the discharge recapitulation was not completed on Resident #52's discharge summary. She continued the nurse who discharged Resident #52 is no longer employed with the facility. The DON stated it is her expectation all departments complete the discharge summary prior to a	TOORTECTION TIDENTIFICATION NUMBER: A. BUILDIN 345404 B. WING ROVIDER OR SUPPLIER VERS HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 failed to complete a recapitulation of Resident #52's stay in the facility. The Director of Nursing (DON) stated during an interview on 11/15/18 at 12:38 PM, the nurse discharging a resident is responsible for completing the discharge recapitulation section of the discharge summary. She stated the discharge recapitulation was not completed on Resident #52's discharge summary. She continued the nurse who discharged Resident #52 is no longer employed with the facility. The DON stated it is her expectation all departments complete the discharge summary prior to a resident's discharge. An interview was completed with the Administrator on 11/15/18 at 2:14 PM. She stated it is her expectation all sections of the	ROVIDER OR SUPPLIER VERS HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 failed to complete a recapitulation of Resident #52's stay in the facility. The Director of Nursing (DON) stated during an interview on 11/15/18 at 12:38 PM, the nurse discharge recapitulation was not completed on Resident #52's discharge summary. She stated the discharge recapitulation was not completed on Resident #52's discharge summary. She stated the DON stated it is her expectation all departments complete the discharge summary prior to a resident's discharge. An interview was completed with the Administrator on 11/15/18 at 2:14 PM. She stated it is her expectation all sections of the discharge summary be complete An interview complete with the Administrator on 11/15/18 at 2:14 PM. She stated it is her expectation all sections of the discharge summary be complete An audit was complete a recapitulation of the DON, MDS, a resident discharge 90 days. Any corcorrected. The procedure for acceptable plan of specific deficiency appears to the procedure of acceptable plan of specific deficiency.	ROVIDER OR SUPPLIER VERS HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PECCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 failed to complete a recapitulation of Resident #52's stay in the facility. The Director of Nursing (DON) stated during an interview on 11/15/18 at 12:38 PM, the nurse discharge recapitulation was not completed on Resident #52's discharge summary. She stated the discharge summary with the facility. The DON stated it is her expectation all departments complete the discharge summary prior to a resident's discharge. A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 1403 CONNER DRIVE WINDSOR, NC 27983 PROVIDER OR THE APPROPRIA DEFICIENCY The PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BIT CROSS-REFERENCE) THE APPROPRIA DEFICIENCY) F 661 F 661 F 661 F 661 F 661 The Indirective Was admitted to complete recapitulation of stay 10f 1 resident rev for a planned discharge from facility to community (Resident #52). The findings included: Resident #52 was admitted to the facility on 7/27/2018 with a diagnosis that included congestive heart failure, atrial fibrillation and hyperlipidemia. Resident #52's admission Minimum Da Set dated 8/3/2018 coded him cognitive intact, requiring limited assistance for most activities of daily living and having the expectation to be discharged to the community. Review of Resident #52's closed recon revealed he was discharged home on 8/15/2018. Further review of closed records revealed the facility failed to complete a recapitulation. An audit was conducted on 12-10-18 by the DON, MDS, and HIMS on 100% of resident discharge summaries for the 16 90 days. Any concerns found are being the provided processory.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 661	Continued From page	e 20	F 6	began in servicing RN's, LPN's on the RN's, LPN's on the The important the resident's stay limited to diagnose illness/treatment or lab, radiology and Completion of resident's status at that is available for persons and agency the resident or resident or resident's post-discharge medical receive in-service final receive in-service will not be allowed has been complete been integrated inforientation training in-service refreshed employees and will Quality Assurance the change has been the plan of correcting specific deficiency and/or in complian requirements:	or therapy, and pertin consultation results. If final summary of the time of discharger release to authorized cies, with the consertident's representative for reconciliation of all dications with the charge medications and over-the-counter. The surses the importance charge checklist to be followed. In the standard of the standard of the standard of the standard of the reviewed by the process to verify that	es: of not ent e ge ed nt of e. e of t 18 0 has has e at nat cted ry

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F 745 SS=D	CFR(s): 483.40(d) §483.40(d) The facility medically-related soci maintain the highest pand psychosocial well This REQUIREMENT by: Based on record revifacility failed to ensure appointments scheduler gall bladder cather the physician for 1 of	r Related Social Service y must provide ial services to attain or practicable physical, mental l-being of each resident. is not met as evidenced ew and staff interviews the e a resident had led every 91 days to have ter replaced as ordered by 1 sampled residents for al services (Resident # 24).	F 745	will audit weekly for four weeks then monthly for three months for completio of the discharge summary. This monitoring will continue until resolved to QOL/QA committee. Reports will be presented to the weekly QA committee the Administrator or DON to ensure corrective action initiated as appropriate Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Administrator DON, MDS Coordinator, Therapy, HIM and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	by e. the or, ,	

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F 745	2/18/09 with diagnose dementia and cholecy in the gall bladder). A review of Resident revealed a physician's	mitted to the facility on es that included cancer, stitis (accumulation of bile	F	745	plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 745	on		
	changed every 91 day discontinued on 11/15 Resident #24's cather				The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Based on record review and staff	е		
	8/19/18 indicated Res hospital due to her ca note further stated sh catheter change Febr indicated Resident #2 the facility and instruc	sident #24 went to the theter not draining. The e missed a scheduled uary 2018. The note 14 was discharged back to			interviews, the facility failed to ensure a resident had appointments scheduled every 91 days to have her gall bladder catheter replaced as ordered by the physician for 1of 1 sampled residents for medically related social services (Resident #24).			
	Resident #24's gall bl 8/28/18.	note dated 8/28/18 revealed adder catheter was changed			The findings included: Resident #24 was admitted to facility of 2/18/2009 with diagnoses that included			
	Data Set (MDS) asse indicated the resident				cancer, dementia, and cholecystitis (accumulation of bile in the gall bladder A review of Resident #24's medical recrevealed a physician's order dated 9/22/16 which indicated her gall bladde	cord		
	information manager indicated that she is r outside appointments scheduling transporta	oith the facility's health on 11/14/18 at 3:16 PM, she esponsible for making for residents and tion. She stated when a ne facility from outside			catheter was to be changed 12/4/2017. Review of an emergency department n dated 8/19/2018 indicated Resident #2 went to the hospital due to her catheter not draining. The note further stated sh missed a scheduled catheter change	ote 4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 745	stated that she was undocumentation of an #24 during the period August 2018 to have changed every 91 daresident's physician. Imanager stated she wappointment was not period. An interview was con AM with Resident #24 He stated Resident #24 He stated Resident #4 and should not have changed unless it was An interview was con Nursing (DON) on 11 stated Resident #24 appointment schedule have her gall bladder DON stated it is her eorders are followed, a contacted the provide to have Resident #24 changed. An interview was con Administrator on 11/1 stated it was her experience.	auld document the edule transportation. She nable to locate appointment for Resident from December 2017 to her gall bladder catheter ys as ordered by the The health information was unsure why an scheduled during this ducted on 11/16/18 at 8:30 d's primary care physician. 24 received comfort care the gall bladder catheter is clogged. ducted with the Director of 1/16/18 at 9:26 AM. She should have had an ed prior to August 2018 to catheter changed. The expectation that physician and staff should have er regarding an appointment is gall bladder catheter ducted with the 6/18 at 10:02 AM. She ectation that physician and a staff member should	F 74	February 2018. The note indical Resident #24 was discharged by facility and instructed to schedul appointment for a gall bladder of exchange. Review of a doctor's note dated revealed Resident#24's gallblad changed 8/28/2018. Review of Resident #24's most Minimum Data Set (MDS) asset dated 9/21/2018 indicated the rewas cognitively impaired. Resident required extensive assistance wactivities of daily living including mobility, locomotion and person hygiene. An audit was conducted 12/10/2 100% of residents with a consultance was identified and correct. The procedure for implementing acceptable plan of correction for specific deficiency cited: On 12-10-2018 the Director of Negan in servicing all FT, PT, at RN's, LPN's, Med Tech's, and Non the following procedures:	ack to the le an eatheter I 8/28/2018 dder was recent essment, esident ent #24 with most j bed hal 2018 on lt in last 90 MS. One		
	appointment for Residual catheter to be change	dent #24's gall bladder ed.		Staff educated on the impo making 2 copies of follow up co			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 745	Continued From page	e 24	F	745	report for DON and HIMS. Staff will be educated on location of mail tray for follow up consultation report for HIMS to pick up Email to be sent to DON by HIMS next scheduled appointment, Any in-house staff member who did not receive in-service training by 12/14/20 will not be allowed to work until training has been completed. This information been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements: The Director of Nursing, MDS Coordinated HIM will audit consults weekly for feweeks then monthly for three months for completion. This monitoring will continuantil resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiate as appropriate. Compliance will be monitored and ongoing auditing programate reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manage.	orts of t 18 d has has at at cted y ator four or ue y ed m ne		

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F 745	Continued From page			The title of the person respons implementing the plan of correct The Administrator is responsible implementation and completion acceptable plan of correction.	ction. le for		12/14/18
SS=E	CFR(s): 483.60(a)(1) §483.60(a) Staffing The facility must empappropriate compete out the functions of the taking into considerat individual plans of ca and diagnoses of the in accordance with the required at §483.70(a) This includes: §483.60(a)(1) A quali clinically qualified nut full-time, part-time, or qualified dietitian or or nutrition professional (i) Holds a bachelor's a regionally accredite United States (or an with completion of the a program in nutrition an appropriate nation recognized for this pu (ii) Has completed at supervised dietetics p	alloy sufficient staff with the incies and skills sets to carry the food and nutrition service, ition resident assessments, are and the number, acuity facility's resident population the facility assessment est. If it is a consultant population to the facility assessment est. If it is a consultant basis. A suffer clinically qualified is one whoto or higher degree granted by the dequivalent foreign degree) the academic requirements of the or dietetics accredited by the all accreditation organization arpose. It is a consultant basis of the process of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 801	services are perform provide for licensure will be deemed to have or she is recognized the Commission on successor organizate requirements of parathis section. (iv) For dietitians him November 28, 2016, no later than 5 years as required by state §483.60(a)(2) If a qualified nuemployed full-time, the person to serve as the nutrition services who will be service with the following years after November 28, (A) A certified dietard (B) A certified dietard (B) A certified food service management certifying body; or D) Has an associate service management, from higher learning; and (ii) In States that have food service management food service managemen	all by the State in which the med. In a State that does not a correctification, the individual ave met this requirement if he as a "registered dietitian" by Dietetic Registration or its ion, or meets the agraphs (a)(1)(i) and (ii) of ed or contracted with prior to meets these requirements after November 28, 2016 or law. Italified dietitian or other utrition professional is not the facility must designate a medirector of food and noprior to November 28, 2016, requirements no later than 5 for 28, 2016, or no later than 1 for 28, 2016 for designations 2016, is: In y manager; or mervice manager, ments for food service	F 8	01			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 801	Continued From page	e 27	F 80	1	
	from a qualified dietiti qualified nutrition profit This REQUIREMENT by: Based on record revinterviews the facility qualified nutritional pr	fessional. is not met as evidenced few, observations and failed to employ a clinically rofessional on a full time		F801 The statements made on this plan of correction are not an admission to a	and do
	basis while the currer manager obtained die The findings included	etary certification.		not constitute an agreement with the alleged deficiencies. To remain in compliance with all fection and state regulations the facility has	deral s taken
	Dietary Manager's en hire date of 5/8/18. T	e facility 's current full time nployment record revealed a 'here was no information rtified dietary manager.		or will take the actions set forth in the plan of correction. The plan of corrections constitutes the facility's allegation of compliance such that all alleged	ection f
	(DM) on 11/15/18 at 1 began her employme 2018. The DM stated dietary manager but s	rith the Dietary Manager 11:35 AM she stated she nt with the facility in May I she was not a certified she had enrolled in an online		deficiencies cited have been or will corrected by the dates indicated. 1. Plan for correcting specific deficiency of the process that led to defi	ency.
	had received her boo Registered Dietitian (monthly and she was telephone if there we stated she was traine	rtified dietary manager and ks. She stated the RD) visited the facility able to call her on the re any questions. She d by corporate certified m other facilities and the RD.		A record review of the facility's current time Dietary Manager's employmer record revealed a hire date of 5/8/2. There was no information that she coertified dietary manager.	nt 018. was a
	course books which v	he DM displayed the online vere located on the DM 's		The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: -	ie
	Dietitian on 11/16/18 was not a full time en	terview with the Registered at 10:30 AM she stated she oployee of the facility. She		The facility will employ a full-time di or a full-time certified dietary manaç	ger.
	basis. She stated she	the facility on a consultant and the certified dietary facilities assisted with		During the interim, an individual had designated by the Administrator to linterim Kitchen Supervisor. Addition	be

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F 801	Continued From page		F 80				
	previous DM left until May. The RD explaine facility's current dietar complete the course v	Ities from the time the the new DM was hired in ed that she thought the ry manager had one year to work to become a certified eet the requirement for tional professional.		clinical guidance and production will be provided by the Consulta and a Certified Dietary Manager another facility on a regular basi updates on recruitment will be p the Administrator.	nt Dietitian from is. Weekly		
	The Administrator was interviewed on 11/16/18 at 12:25 PM. She stated the facility's RD worked at the facility on a consultation basis and was not a full time employee of the facility. The Administrator stated the facility's current DM was not certified but she thought the facility was allowed one year from the dietary manager's hire date for her to obtain certification to be			The monitoring procedure to enter the plan of correction is effective specific deficiency cited remains and/or in compliance with the rerequirements:	ion is effective and that cited remains corrected		
		d nutritional professional.		The Position Description for the Services Director Position is bei to meet CMS guidance. The fac actively recruiting a qualified Die Manager who meets Position Derequirements.	ng revised ility is etary		
				The title of the person responsible implementing the plan of correct The Administrator is responsible implementation and completion acceptable plan of correction.	tion. e for		